Primary Care Medicines Reconciliation

Presentation to: 2nd National Medicine Reconciliation Workshop

06 September 2011

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With thanks to Marilyn Tucker – Compass Health

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GENERAL PRACTICE NZ
The Heart of Health Care Networks

The Royal New Zealand College of General Practitioners

IT HealthBoard

The Primary Care Opportunity

Every day in New Zealand

1,200 people are admitted to hospital,
2,000 visit an ED
and

50,000 visit 1086 general practices

General Practice represents
15m consults and approximately 30-40m clinical decisions per annum

PATIENTS FIRST
Quality and Information for best outcomes

Meds Rec in Primary Care

- Introduced in Secondary care
- Small “pockets” of activity in primary care
- Hypothesis = largest risk in primary care medicines management is between hospital discharge to residential care

- Multiple “fault lines” between secondary care to residential care identified
- Highlights need for inter-disciplinary teamwork, agreed content and flow, timeliness of information

Residential Care context

- high degree of complexity in terms of co-morbidity and long term conditions
- patients in residential care are typically on a high number of medications;
- the higher threshold for entry to residential care means a higher-needs group, with increasing numbers of patients with dementia
- the part-time and fragmented/decentralised nature of the medical workforce supporting residential care provides less continuity and availability of staff supporting an increasingly at-risk population.

Issues Summary

- the flow of information from residential care accompanying the patient (Medications on admission);
- lack of continuity between clinicians providing treatment to the patient and those preparing the discharge summary
- the number of medication related discrepancies on discharge information from hospital

Issues Summary contd

- gaps in information relating to the complete list of medication on admission and discharge
- the time lag between patients being discharged and the discharge summary following them; and,
- the lack of standardised practice and policy of hospitals sending a copy of the discharge summary to the community pharmacy associated with the residential care facility.

Scenario

Patient A is discharged from Hospital at 4.00pm on Friday afternoon back to their residential care facility.

The discharge prescription lists one medication.

The patient has co-morbidities and, when originally admitted to hospital, was on 9 medications.

The pharmacist is concerned – "is this one medication replacing all original 9? Is this an additional medication? Was the specialist aware of the other medications the patient was on and any contra indications between the newly prescribed medication and the original medications?"

Attempts at contacting the hospital to get further information are unsuccessful. It is now after 5.00pm on a Friday.

Baseline data

- *Pre-pilot data collection at a selected site:*
- Small sample (11 patients)
  - *Only 10 included as one was a new patient to home and had no former history at the pharmacy and no comparator data*
  - *One other new patient had comparator data as previously a patient at the pharmacy*
- Avg no of meds before admission = 9.7
- Avg no of PRN meds before admission = 3.2
- Avg number of topical medicines = 1.4
- Avg rate of discrepancies = 4.5 per patient *

(compared with 2.9 in hospital setting)*

Process issues

- are many…a cross sample of which include
  - Need for better, more timely information to all residential care health professionals involved with patient
  - Need for improved communications between hospital, community pharmacy, facility and GP
  - Discharge summaries (incomplete or incorrect medicines information, not getting to all who need it, time lag at times)
  - If unit/ward is general and has multiple profiles of patient, the focus is spread across all and not weighted to risk/needs of older people – time delays and gaps/inaccuracies in information

Readiness for MedRec?

- The prescription does not include Allergies and ADR information (fundamental for Pharmacists though not standard practice)
- Process review highlights gaps in process, information and time-lags (confounding factors) in discharge
- Multiple sources of reliable information not available to allow triangulation for MedRec

- BUT – can move toward bridging some gaps on the way to (future) MedRec – and reduce risk now

Recommendations (1/2)

1. A policy position to DHBs on making hospital discharge information available to community pharmacists who are part of the residential care teams
2. A copy of the discharge summary to be sent to the community pharmacist directly from the hospital.
3. A copy of the patient's hospital medication chart to be sent to the community pharmacist

Recommendations (2/2)

4. A Clinical education module for General Practice (via RNZCGP and Cornerstone) around prescribing and a suite of measurements to evaluate the effectiveness of this
5. Consider the adoption of a 7-day interim medication chart for patients discharged from Hospital to Residential Care.
6. Standardisation of all information, both in content and format, being transmitted between hospital and residential care and vice versa is a high-priority
7. Review and improvement of hospital discharge processes